# TESTIMONY OF JOHN HORNBEAK,

# PRESIDENT & CEO

# METHODIST HEALTHCARE SYSTEM

## BEFORE THE

# HOUSE ENERGY AND COMMERCE COMMITTEE

# SUBCOMMITTEE ON HEALTH

# HEARING ON

# PHYSICIAN-OWNED SPECIALTY HOSPITALS

# MAY 12, 2005

# Summary of Testimony
# Before the
# House Energy and Commerce Committee
# Subcommittee on Health
# Physician-owned Specialty Hospitals
# May 12, 2005

John Hornbeak, President and CEO of the Methodist Healthcare System of San Antonio is representing the Methodist System, The Hospital Corporation of America (HCA, Inc.) and the Federation of American Hospitals. Physician-owned specialty hospitals are having a profoundly negative effect on our nation's health care system and their continuation will impact the ability of full-service hospitals to continue to offer the services communities need and expect.

The specialization of health care services and the existence of specialty hospitals is not the problem. It is the physician ownership of, and self-referral to, these facilities that creates an anti-competitive environment and unlevel playing field.

At issue are the federal anti-referral and anti-kickback laws. The "whole hospital" exception loophole in the self-referral prohibition law permits physician-owned specialty hospitals to cherry pick only the most profitable patients, leaving to community hospitals high-cost patients, individuals on Medicaid, and the uninsured. Numerous studies raise questions about the manner in which these facilities operate. For example, both MedPAC and GAO found physicians owning a financial interest in a specialty hospital tended to direct to their facilities only the most attractive patients, e.g. those who are not Medicaid or those who are less sick. This type of referral behavior was not the intent of Congress when it enacted the self-referral bans.

The solution is to close the loophole in the physician self-referral law and continue the moratorium until the self-referral law is amended. The whole hospital exception loophole is not in the best interest of our patients, and it will continue to undermine the vital health care services your communities expect from your full-service community hospitals.

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## INTRODUCTION

Good Morning. My name is John Hornbeak, and I am the President and CEO of the Methodist Healthcare System of San Antonio. I am delighted to be here today to testify on behalf of the Methodist system, the Hospital Corporation of America (HCA, Inc.), and the Federation of American Hospitals.

The Methodist Healthcare System is a taxable partnership between the not-for-profit Methodist Ministries and HCA, Inc., the nation's largest provider of health care. The Methodist Healthcare System comprises five full-service acute care hospitals, with more than 1,500 beds. We serve the San Antonio, Texas, market as well as twenty-five surrounding counties.

I am delighted to be here this morning to discuss the unique problems created by physician ownership of, and self-referral to, specialty hospitals. I view this as one of the most critical issues facing full-service community hospitals today. By injecting self-referral into the clinical process, physician-owned specialty hospitals undermine and complicate the delivery of responsible, effective health care.

## BACKGROUND

Let me begin by stating that as CEO of a large health care system, I certainly understand the pressures faced by both hospitals and physicians. We all must overcome numerous obstacles just to keep open the doors to quality patient care—the constraints of often unpredictable and inadequate Medicare and Medicaid reimbursement, increasing medical liability insurance premiums, pressures of managed care, demanding regulatory burdens, and on-call requirements, are just a few of the challenges. Within this demanding environment, it is understandable that some physician specialists would be seduced by a specialty hospital's promise of incomparable personal financial gain. However, I believe that each of these challenges requires a comprehensive solution aimed at reforming a fractured health care system, not an anti-competitive solution in the form of self-referral to specialty hospitals, which ultimately impacts patient access to health care. By not confronting the underlying public policy problems of allowing physician ownership and self-referral, we are creating a potentially devastating trend in the way health care is delivered, the long term results of which are far worse than the underlying issues which in part have caused them.

I am deeply concerned about the effect physician-owned specialty hospitals are having on our health care system, and how their continued proliferation will impact the ability of full-service hospitals to continue to offer the services communities need and expect. I am also concerned about the duplicative nature of these facilities, which invariably leads to increasing health care costs at a time when our public health care infrastructure is financially stressed on both the state and federal levels.

When Congress enacted the physician self-referral ban, it did not envision the development of facilities whose business model relied upon the control of referrals by its physician-owners. However, within the past several years, physician-owned specialty hospitals have emerged to capitalize on an unintended loophole in this law. The business model arrangements provide physician-owners with strong monetary incentives for referring carefully selected patients to the facilities in which the physicians have ownership interests, while leaving less profitable cases to be handled by local community hospitals.

As both the independent Medicare Payment Advisory Commission (MedPAC) and Government Accountability Office (GAO) found, physicians owning a financial interest in a specialty hospital tend to direct to their facilities only the most attractive patients—those who are not on Medicaid or those who are less sick. However, those same specialists tend to refer underinsured or uninsured patients, as well as those with higher acuity (more complexity), to full-service community hospitals for treatment. The care provided to underinsured or uninsured patients at the full-service community hospital is often administered with little to no reimbursement of costs. Consequently, full-service hospitals then are left without adequate resources to treat the sickest patients.

This practice of patient selection is unethical, and does not serve the best interests of the American health care system, community hospitals, and most importantly, the patients in our care.

I am not alone in expressing these concerns. Study after study continues to reach similar conclusions and raise questions about the manner in which these facilities operate. These studies include: GAO reports from April 2003 and October 2003; MedPAC report from March 2005 ; Dr. Peter Cram's recent analysis in the *New England Journal of Medicine;* Dr. Jean Mitchell's

analysis of specialty hospitals in Arizona and Oklahoma markets; report from O'Melveny & Myers LLP and KPMG dated July 3, 2003; McManis Consulting case studies of markets in South Dakota, Nebraska, Oklahoma and Kansas; and Cara Lesser with the Center for Health System Change analysis of inappropriate utilization, to name just a few. The gravity of the issues highlighted in these studies, the long term health care cost implications, and the striking potential for the creation of a tiered health care delivery system is dividing the physician community and is leading other, non-hospital groups to express their opposition to physician-owned specialty hospitals. In fact, the American Academy of Family Physicians , American College of Emergency Physicians, the U.S. Chamber of Commerce, and the National Black Chamber of Commerce have all recently expressed their support for extension of the moratorium on new physician-owned specialty hospitals. The U.S. Chamber of Commerce, in a letter from Thomas Donohue to Chairman Bill Thomas states: "The Chamber favors a market-based health care system that is rooted in competition based on the highest possible (sic) quality, excellent outcomes and reasonable price." He concludes his letter by saying, "The Chamber believes further evaluation of this topic is warranted, and thus urges an extension of the current moratorium." More recently, in a May 2, 2005 front page article, the *Wall Street Journal* raised questions about the concept of self-referral and the link to utilization of services.

It is my understanding that the specialty hospital industry is prepared to move forward with the development of new facilities if the moratorium expires in June 2005. As stated in a November 15, 2004 issue of *Modern Healthcare*, "Donald Burman, Chief Executive Officer of the 27-bed Orthopedic Hospital of Oklahoma in Tulsa, said he believes that there are at least '100 facilities out there ready to go if the moratorium' is lifted next June. 'You could see 250

more in the next few years.'" This is entirely consistent with what I am hearing throughout Texas.

The only way to solve this problem is to close the loophole in federal self-referral prohibition by permanently banning physician ownership of, and self-referral to, specialty hospitals. The success of these facilities depends entirely upon the physician owners' referrals, and this type of relationship is exactly what the self-referral ban is designed to prevent.

## SELF-REFERRAL IS THE ISSUE

As the CEO of five full-service acute care community hospitals in a vigorous healthcare market, I am committed to supporting free and fair competition. True competition, however, requires a level playing field. Methodist Healthcare System, and other full-service community hospitals nationwide, routinely compete for patients on the basis of quality of care, physician recruitment, and provision of the latest medical technologies. Yet the recent proliferation of physician-owned specialty hospitals in Texas and across the country has dramatically altered the delivery of health care services by stifling fair competition and even threatening the viability of certain vital health care services nationwide.

The *existence* of specialty hospitals is not the problem. Instead, it is the *physician ownership of and self-referral to* these facilities that creates an uneven playing field and directly harms full-service community hospitals. In recent years, physician-owned specialty hospitals built across the country are distorting the marketplace wherever they appear. These facilities limit their care to just one type of high-margin service—often cardiac, orthopedic, or surgical care—which guarantees high profit margins, while avoiding essential but unprofitable community-based services, such as emergency departments and burn units.

Ownership interests in these facilities are typically granted only to physician-investors who are able to refer patients, not to any investors from the general public. Referring physicians are given sweetheart equity arrangements, with little risk, at bargain basement rates. In contrast, offering a physician any "inducement" for referrals would land me in jail under the anti-kickback law. These laws together prohibit me from giving specialists at my hospital more than $300 in gifts per year, none of which could be given in exchange for an induced referral. Fair competition under the current interpretation of the self-referral ban is simply impossible.

The "whole hospital" loophole in the self-referral prohibition permits specialty hospitals to cherry pick only the most profitable patients, leaving to community hospitals high-cost patients, individuals on Medicaid, and the uninsured. GAO and MedPAC have found clear evidence of this behavior, concluding that physician ownership and self-referral result in favorable patient selection. Because of their adverse financial impact, self-referrals to physician-owned specialty hospitals threaten the long-term viability of our full-service community hospitals.

## QUALITY

Proponents of physician-owned specialty hospitals often suggest that quality is superior in these settings. Until very recently, no independent, non-industry supported, data existed to support or refute this assertion. However, Dr. Peter Cram from the University of Iowa found in a study recently published in the *New England Journal of Medicine* that quality is in fact no better in a specialty hospital setting. Specifically, Dr. Cram found that "there is no definitive evidence that cardiac specialty hospitals provide better or more efficient care than general hospitals with similar procedural volumes." Moreover, Dr. Cram found that specialty heart hospitals treat fewer seriously ill patients than community hospitals, creating the illusion they provide better

care, and "given that we found no significant differences in outcomes between specialty and general hospitals with similar volumes or between specialty cardiac hospitals and specialized general hospitals, it could be argued that the specialty-hospital model itself does not yield better outcomes."

The findings of the study also reinforce previous conclusions found by MedPAC and GAO that specialty hospitals cherry pick healthier patients. In an interesting development, Dr. Cram also found that patients receiving care in physician-owned specialty hospitals "resided in ZIP Code areas with somewhat higher socio-economic status, as evidenced by higher mean home values and higher per capita income." I find it troubling that specialty hospitals, when injecting physician ownership into the equation, are creating a foundation for the development of an "economically-tiered" health care delivery system.

## COMMITMENT TO COMMUNITY

In this anti-competitive environment, full-service community hospitals struggle to achieve the level of care that we desire to provide, and that our communities expect. When specialty hospitals drain essential resources from full-service community hospitals, they particularly harm, over time, our capacity to provide emergency care and other vital health services.

The Methodist Healthcare System believes that maintaining a fully functioning and fully staffed twenty-four hour emergency department is part of our commitment to the community. In 2004, we received 180,000 visits to our emergency department. Physician-owned specialty hospitals simply do not share in the full compliment of critical ED services, which full-service hospitals consider as a responsibility and commitment to their communities. In fact, during one

site visit, MedPAC noted that a specialty hospital had to turn on the light to show what it claimed as its emergency department. Many others have no emergency department at all.

As the Members of this Committee are well aware, America's hospital emergency departments are quickly becoming our *de facto* public healthcare system, the primary point of access to quality healthcare services for the nation's uninsured. Hospitals equipped with emergency departments must provide medical evaluation and required treatment to everyone, regardless of their ability to pay. Since the advent in recent years of physician-owned specialty hospitals, which skim profitable service areas for low-risk patients, the emergency department burden has grown significantly greater. While specialty hospitals treat the most profitable patients, full-service hospitals are left with the task of handling uninsured and high-risk patients within their community. At Methodist Healthcare System, 41 percent of patients who visited our emergency department in 2004 were self-pay/indigent or Medicaid patients. Maintaining this essential community service for those who need it most also means contending with a regular population of those with little or no health care options. Moreover, this population often seeks emergency room care only once an illness has reached a level of acuity that makes their case more complex and costly to handle.

A 2003 GAO study sheds considerable light on the attitude of specialty hospitals toward emergency services. According to the GAO, a majority of specialty hospitals do not have fully functioning, fully staffed, twenty-four hour emergency departments. The GAO study reveals that while nine in ten of all full-service community hospitals maintain an emergency department to address any medical situation that walks or is carried through its doors, half of all specialty hospitals do not provide emergency services. Even among those specialty hospitals that do have emergency departments, GAO found that the care provided was almost entirely within the

specialty hospital's field. By opting not to operate fully functioning emergency departments, specialty hospitals enjoy a high degree of self-selection, which allows them to treat a healthier and better paying patient population with fewer complications and shorter lengths of stay. In my market, I regularly see specialty hospitals avoid this commitment to our community. For example, while the local MedCath facility does maintain an ED, it states quite openly that it is only for cardiac emergencies. In addition, the President and CEO of Austin Surgical Hospital, Patricia Porras, stated "Structurally, there is an ED department. However, we will not pursue a public ER, and we will not be tied into an EMS system."

Moreover, GAO and MedPAC separately found that specialty hospitals treat a much smaller share of Medicaid patients than do community hospitals within the same market area. In its results, MedPAC found that physician-owned specialty hospitals treat far fewer Medicaid recipients than do community hospitals in the same market—75 percent fewer for heart hospitals and 94 percent fewer for orthopedic hospitals.

The departure of specialists who relocate their practices from full-service community hospitals to physician-owned specialty facilities causes an additional strain on specialty coverage for full-service hospitals. Communities expect full-service hospital emergency departments to maintain a complete state of readiness around the clock, every day of the year. On-call requirements for specialists ensure adequate staffing outside normal work hours, as well as on holidays and weekends for hospital emergency departments. The lack of physician specialists to provide coverage at full-service community hospitals has compromised the ability of those hospitals to provide twenty-four hour emergency services and to meet the significant obligations hospitals face under the Emergency Medical Treatment and Active Labor Act.

Recognizing the importance of our role in the community, the Methodist Healthcare System also provides a vital charity care program, and has made significant investments in specialized, essential state-of-the-art health care services, such as transplant, open heart, neurosurgery, children's health care, rehabilitation, psychiatric care, and neonatal intensive care. It is important to note that the Methodist Healthcare System is a proponent of specialization and its benefits; however, it is equally important to note that none of these inpatient specializations are physician-owned. The benefits of specialization can be achieved without the inherent conflict of interest found in physician-owned specialty hospitals.

## IMPACT ON METHODIST HEALTH SYSTEM

Like full-service community hospitals nationwide, the loss of specialists willing to cover on-call responsibilities poses a significant cost to community hospitals nationwide, and directly threatens patient care. Prior to the development of physician-owned specialty hospitals within the San Antonio area, our specialists largely accepted on-call responsibilities as a member of the volunteer medical staff and pro-bono commitment to our community. However, following the development of the Spine Hospital of South Texas, in particular, the Methodist Healthcare System has been unable ensure on-call participation of those orthopedists who are part-owners in the specialty facility.

The Methodist Healthcare System prides itself in working with all physician specialists within the community and ensures their access to our facilities. Nevertheless, this is often done at a significant cost to our hospital. Many of the cardiac surgeons with ownership in the MedCath facility direct the healthier, less complex patients away from our hospital and admit them to the MedCath facility in which they have an ownership interest. The only time we see those patients again is when complications arise.

Proponents of physician-owned specialty hospitals claim that their presence in a community generates efficiencies and lowers costs. This could not be further from the truth. MedPAC found that specialty hospitals do not have lower Medicare costs per case, even though they treat healthier patients for a shorter period of time than full-service community hospitals do. In addition, when specialty hospitals enter a community, their services are generally duplicative and impose significant cost burdens on the full-service hospitals, which must both compete and continue to meet the needs of the community that specialty hospitals shun.

## PHYSICIAN-OWNED SPECIALTY HOSPITALS ARE DIVERTING NEEDED RESOURCES FROM FULL-SERVICE COMMUNITY HOSPITALS

Full-service community hospitals long have used funds generated by higher margin services to subsidize the losses suffered by less financially desirable services. Only by maintaining the successful product lines are full-service hospitals able to subsidize other critical but (less financially advantageous) services, such as trauma and burn centers, as well as fund special programs for delivering care to uninsured and underinsured patients. By removing the highest margin services from full-service community hospitals, physician-owned specialty facilities have a monetary incentive to refer only those better-funded and less severely ill patients. This leaves the uninsured, underinsured and more severely ill patients to be treated by community hospitals, often without adequate (or any) compensation. While paying and less severely ill patients are diverted to physician-owned specialty facilities, community hospitals are left with the burden of caring for a higher percentage of the uninsured, underinsured, and the sickest patients, yet with fewer resources to cover the vast and unreimbursed costs involved.

## FEDERATION OF AMERICAN HOSPITALS' PETITION

Fundamental to understanding the proliferation of physician-owned specialty hospitals is recognizing how this industry has abused the whole hospital exception to the physician self-referral ban. As this Committee is aware, the self-referral ban was intended to prohibit questionable conflict of interest arrangements between physicians and providers that could lead to an abuse of the Medicare program. This law generally prohibits physician referrals for Medicare services to entities in which the physician has an ownership interest. The intent of this prohibition was to establish and maintain a thriving marketplace for health care, free of conflicts of interest and protecting the integrity of the Medicare program. Under current law, physicians are permitted to have an ownership interest in an entire full-service inpatient hospital, but not a subdivision of a hospital. The logic behind the exception is that any referral by a physician who has a stake in an entire hospital would produce little personal economic gain, because hospitals tend to provide a diverse and large group of services. However, a physician's ownership in a subdivision of a hospital would not sufficiently dilute the potential conflict of interest and, instead, would constitute a material conflict of interest regarding improper influence over physician referrals.

Clearly, the intent of Congress was to prohibit physician ownership of and referral to subdivisions such as cardiac, surgical or orthopedic wings. It is difficult for me to imagine how a facility that has five beds or even twenty-five beds is a full-service hospital. The average bed size of a surgical hospital, according to MedPAC, is 15 beds. These facilities, however, have taken advantage of state hospital licensing laws which allow them to be considered "whole hospitals," circumventing the intent of the whole hospital exception in the anti-referral law.

There is no question, in my professional opinion, physician-owned specialty hospitals are effectively subdivisions of full-service hospitals. It is my hope that Congress will revisit this issue and address this new type of facility legislatively. In the meantime, it is important to recognize the role the Department of Health and Human Services (HHS) can play in re-examining the definition of a whole hospital. To this end, our trade association, the Federation of American Hospitals, petitioned HHS on February 28, 2005, to define a whole hospital. The Federation argues that because Congress did not intend to protect physician-owned limited service facilities under the whole hospital exception, HHS is obligated to take action so its regulations adapt to changing circumstances. Specifically, the Federation's petition recommends refining the whole hospital exception to apply only to "full-service hospitals."

Physician-owned specialty hospitals are clearly different from community hospitals, and therefore, should be analyzed separately and addressed in the regulation under the whole hospital exception. In the petition, the Federation urges the whole hospital exception regulation be changed to include a more refined definition of whole hospital that focuses on demographics and service mix, in addition to state licensure status. I believe that continuing to allow physician-owned specialty hospitals to qualify as whole hospitals under this regulation is a triumph of form over substance and thwarts Congressional intent to protect the Medicare program from over-utilization and self-induced demand.

## SOLUTION: CLOSE THE SELF-REFERRAL LOOPHOLE

Allowing for the continuation of these unethical financial arrangements between referring physicians and specialty hospitals is tantamount to purchasing admissions. I understand that Congress is weighing recommendations by MedPAC that would seek to level the playing field through Medicare payment adjustments. While I would certainly advocate for more accurate and

appropriate Medicare reimbursement, I think it is important to recognize that Medicare payment adjustments alone will not level the playing field and will not solve the exploitation of this loophole.

MedPAC was correct in recognizing the problems inherent in physician ownership of specialty hospitals, and the need to prevent such conflicts of interest; however, its recommended policy response, which focused on refinements of Medicare's DRG payment system, is inadequate. As an operator of acute care hospitals, I can assure the Committee that simply adjusting the DRG's will only marginally reduce the profitability of self-referral. It is the ownership and referral relationship that creates patient selection. The underlying economics of these facilities, which rely upon referrals from physician-owners, would not change materially. Furthermore, while some modifications of the DRG payment system may be warranted, we have to be careful that the wholesale refinement of the DRG system, which MedPAC proposes, could threaten the original reasons for, and subsequent achievements of, the Prospective Payment System we have in place today – that is, rewarding efficient providers. While payment refinements will not solve the self-referral problem, I can tell you that the massive redistribution of funds nationwide would have the unintended consequence of hurting some full-service community hospitals, even in markets where there are now no physician-owned specialty hospitals. We have to be extremely careful about a solution this broad in scope that in my opinion does not address the central problem of physician self-referral.

## CONCLUSION

Ultimately, the only effective solution for the Methodist Healthcare System and for hospitals nationwide demands an amendment to the physician self-referral prohibition. The "whole hospital" exception was intended to allow physician ownership in a comprehensive

health care facility, as long as that ownership interest is in the entire facility and not merely a subdivision. Congress never contemplated the proliferation of specialty hospitals, which essentially have turned the entire concept of the "whole hospital" exception on its head. In my professional opinion, specialty hospitals are not whole hospitals; rather they are akin to subdivisions of hospitals–essentially cardiac, surgical, or orthopedic wings–that have been removed from the full-service hospital. As such, I believe physician referral to specialty hospitals in which they have an ownership interest is as clear a violation of the anti-referral law as would be physician ownership in a hospital subdivision. Simply put, under the present interpretation of the "whole hospital" exception, physician-owned specialty hospitals are exploiting an unintended loophole to engage in precisely the financial arrangement that Congress intended to prohibit. This situation must be changed.

Not only must the current moratorium be extended, but also it is my hope that Congress will close the loophole in the physician self-referral ban that allows for self-referral to physician-owned specialty hospitals. The whole hospital exception loophole is not in the best interest of our patients, and it will continue to undermine the vital health care services your communities expect from your full-service community hospitals.

Thank you for your time. I would be glad to answer any questions.

**JOHN E. HORNBEAK, FACHE**

**President and C.E.O.**
**Methodist Healthcare System of San Antonio, Ltd.**

John E. Hornbeak was appointed President and Chief Executive Officer of the Methodist Healthcare System of San Antonio on January 11, 1995 and is also currently serving as the Chief Executive Officer of Southwest Texas Methodist Hospital and Methodist Specialty & Transplant Hospital. Prior to his appointment as the President and CEO of the Methodist Healthcare System, he served as the Chief Executive Officer of Southwest Texas Methodist Hospital since 1987.

Mr. Hornbeak earned his Master's Degree in Health Care Administration from the University of Alabama in Birmingham, and he has a B.A. Degree from the Methodist-affiliated Birmingham-Southern College.

Before joining Methodist, Mr. Hornbeak had been the Executive Director of Humana Hospital-San Antonio from 1985 to 1987. He was the Executive Director of Humana Hospital-Huntsville in Alabama for seven years. He also spent three years as the Assistant Administrator of the University Medical Center Hospital in Mobile, Alabama.

Mr. Hornbeak is a Fellow of the American College of Healthcare Executives, and his professional affiliations include memberships in the American Hospital Association, the Texas Hospital Association, and the Greater San Antonio Hospital Council. He is currently serving on the Health Careers Foundation Board and the Greater San Antonio Chamber of Commerce Board of Directors.

Mr. Hornbeak is married to Charlotte, a native San Antonian, and the couple has three grown sons.